

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032277

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8487

FILED SEP 10 1962

VS 300
Rev. 4/59

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240353

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60-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN Pagedale		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FAITH HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1323 Milford Ave.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pete Middle BIONDO Last						4. DATE OF DEATH Month 8 Day 30 Year 62					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-15-96		9. AGE (last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Presser				10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Angelo Biondo				13b. MOTHER'S MAIDEN NAME Rose Biancalione				14. NAME OF HUSBAND OR WIFE Lena Biando			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give year or dates of service) None				16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Mrs. Lena Biondo 1323 Milford Ave. (23)					
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC ENTEROCOLITIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 571.1 DUE TO (c) ARTERIOSCLEROTIC HEART DIS. BRONCHOPNEUMONIA										INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DIS. BRONCHOPNEUMONIA										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION				COUNTY		STATE			
21. I attended the deceased from JAN 29, 1960 to AUG 30, 1962 and last saw him alive on AUG 30, 1962 Death occurred at 2:50 AM m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Donald Freedman, M.D. (Degree or title)						22b. ADDRESS 1504. Meramec, Clayton 5, Mo			22c. DATE SIGNED 9/4/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-4-62		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. LOUIS, Missouri		23e. STATE Missouri			
24. FUNERAL DIRECTOR Calvin F. Feutz 4828 Natural Bridge Blvd						25. DATE RECD. BY LOCAL REG. SEP 4 1962		26. REGISTRAR'S SIGNATURE Donald Smith. M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. David Feldman
150 N. Meramac
PA 6-2611

Hours: 11 AM to 1:30 PM
1 PM to 3:30 PM Sat. ← *will sign*

~~Dr. M. A. Cassell
3400 N. Kingshighway
EV 5-1050
Hours: 1 PM to 4 PM
1 to 4 Sat.~~

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John A. Mlinar

Licensed Embalmer No. 4186

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.